		FOR OHF USE					

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042416

Facility Name: PLEASANT VIEW

Address: 500 NORTH JACKSON STREET (Number) MORRISON (City) 61270 (Zip Code)

County: WHITESIDE

Telephone Number: 815-772-7288 **Fax #** 815-772-2399

IDPA ID Number: 36-2819435003

Date of Initial License for Current Owners: 12/6/96

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		Z	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: ALAN GAPINSKI **Telephone Number:** 815-778-3683

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/05 to 12/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) ALAN GAPINSKI
(Title) PRESIDENT

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number PLEASANT VIEW # 0042416 Report Period Beginning: 1/1/05 Ending: 12/31/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 09/01/2004

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	8	Skilled (SNF)	8	2,920	1
2		Skilled Pediatric (SNF/PED)			2
3	66	Intermediate (ICF)	66	24,090	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	74	TOTALS	74	27,010	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	751	18	392	1,161	8
9	SNF/PED					9
10	ICF	12,541	8,096	0	20,637	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,292	8,114	392	21,798	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.70%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 12/6/96

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/6/96 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 8 and days of care provided 392

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/05 Fiscal Year: 12/31/05

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number PLEASANT VIEW # 0042416 **Report Period Beginning:** 1/1/05 **Ending:** 12/31/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	173,333	17,835	7,425	198,593		198,593		198,593			1
2	Food Purchase		144,696		144,696		144,696	(3,655)	141,041			2
3	Housekeeping	50,266	15,171		65,437		65,437		65,437			3
4	Laundry	31,703	17,152		48,855		48,855		48,855			4
5	Heat and Other Utilities			75,184	75,184		75,184	(4,905)	70,279			5
6	Maintenance	60,212	21,620	9,188	91,020	180	91,200	257	91,457			6
7	Other (specify):*											7
8	**TOTAL General Services**	315,514	216,474	91,797	623,785	180	623,965	(8,303)	615,662			8
	B. Health Care and Programs											
9	Medical Director			3,000	3,000		3,000		3,000			9
10	Nursing and Medical Records	832,234	99,001	3,074	934,309	(15,805)	918,504	(15,881)	902,623			10
10a	Therapy	24,075		10,778	34,853		34,853		34,853			10a
11	Activities	46,670	7,540	920	55,130		55,130		55,130			11
12	Social Services	34,689			34,689		34,689		34,689			12
13	CNA Training	9,838		5,650	15,488		15,488		15,488			13
14	Program Transportation	10,803	3,214		14,017	(10,513)	3,504		3,504			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	958,309	109,755	23,422	1,091,486	(26,318)	1,065,168	(15,881)	1,049,287			16
	C. General Administration											
17	Administrative			116,983	116,983		116,983	(26,390)	90,593			17
18	Directors Fees											18
19	Professional Services			9,938	9,938		9,938	610	10,548			19
20	Dues, Fees, Subscriptions & Promotions			40,672	40,672		40,672	(26,141)	14,531			20
21	Clerical & General Office Expenses	39,980	13,101	9,710	62,791		62,791	1,855	64,646			21
22	Employee Benefits & Payroll Taxes			244,916	244,916		244,916	13,629	258,545			22
23	Inservice Training & Education			43	43		43		43			23
24	Travel and Seminar			6,570	6,570		6,570		6,570			24
25	Other Admin. Staff Transportation			1,875	1,875		1,875	717	2,592			25
26	Insurance-Prop.Liab.Malpractice			38,610	38,610		38,610	415	39,025			26
27	Other (specify):* SALES TAX			792	792		792	(792)				27
28	**TOTAL General Administration**	39,980	13,101	470,109	523,190		523,190	(36,097)	487,093			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,313,803	339,330	585,328	2,238,461	(26,138)	2,212,323	(60,281)	2,152,042			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number PLEASANT VIEW #0042416 **Report Period Beginning:** 1/1/05 **Ending:** 12/31/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			58,860	58,860	(180)	58,680	31,693	90,373			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			30,882	30,882		30,882	68,452	99,334			32
33	Real Estate Taxes			38,115	38,115		38,115		38,115			33
34	Rent-Facility & Grounds			155,698	155,698		155,698	(155,697)	1			34
35	Rent-Equipment & Vehicles			6,000	6,000	(4,500)	1,500		1,500			35
36	Other (specify):* **GOODWILL**			11,316	11,316		11,316	(11,316)				36
37	**TOTAL Ownership**			300,871	300,871	(4,680)	296,191	(66,868)	229,323			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					15,013	15,013		15,013			38
39	Ancillary Service Centers					11,017	11,017		11,017			39
40	Barber and Beauty Shops					4,788	4,788		4,788			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			40,515	40,515		40,515		40,515			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			40,515	40,515	30,818	71,333		71,333			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,313,803	339,330	926,714	2,579,847		2,579,847	(127,149)	2,452,698			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number PLEASANT VIEW # 0042416 Report Period Beginning: 1/1/05 Ending: 12/31/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,655)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,905)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(1,011)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(792)	27		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(800)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(20,287)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(4,448)	20		28
29	Other-Attach Schedule See page 5A	(28,009)	var		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (63,907)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(63,242)	various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (63,242)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (127,149)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.	X		$ 15,013	14,35	38
39	P.A. OXYGEN	X		11,017	10	39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops	X		4,788	10	41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 30,818		47

PLEASANT VIEW

ID# 0042416

Report Period Beginning: 1/1/05

Ending: 12/31/05

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	FLOWERS	$ (812)	20	1
2				2
3	GOODWILL	(11,316)	36	3
4	EMPLOYEES AT OTHER FACILITIES	(15,881)	10	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(28,009)		49

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number PLEASANT VIEW **#** 0042416 **Report Period Beginning:** 1/1/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,655)	0	0	0	0	0	0	0	0	0	0	(3,655)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(4,905)	0	0	0	0	0	0	0	0	0	0	(4,905)	5
6	Maintenance	0	0	257	0	0	0	0	0	0	0	0	257	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(8,560)	0	257	0	0	0	0	0	0	0	0	(8,303)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(15,881)	0	0	0	0	0	0	0	0	0	0	(15,881)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(15,881)	0	0	0	0	0	0	0	0	0	0	(15,881)	16
	C. General Administration													
17	Administrative	0	0	(26,390)	0	0	0	0	0	0	0	0	(26,390)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	350	260	0	0	0	0	0	0	0	0	610	19
20	Fees, Subscriptions & Promotions	(26,347)	0	206	0	0	0	0	0	0	0	0	(26,141)	20
21	Clerical & General Office Expenses	0	0	1,855	0	0	0	0	0	0	0	0	1,855	21
22	Employee Benefits & Payroll Taxes	0	0	13,629	0	0	0	0	0	0	0	0	13,629	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	717	0	0	0	0	0	0	0	0	717	25
26	Insurance-Prop.Liab.Malpractice	0	0	415	0	0	0	0	0	0	0	0	415	26
27	Other (specify):*	(792)	0	0	0	0	0	0	0	0	0	0	(792)	27
28	**TOTAL General Administration**	(27,139)	350	(9,308)	0	0	0	0	0	0	0	0	(36,097)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(51,580)	350	(9,051)	0	0	0	0	0	0	0	0	(60,281)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PLEASANT VIEW # 0042416 **Report Period Beginning:** 1/1/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	30,769	924	0	0	0	0	0	0	0	0	31,693	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,011)	68,433	1,030	0	0	0	0	0	0	0	0	68,452	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(155,697)	0	0	0	0	0	0	0	0	0	(155,697)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(11,316)	0	0	0	0	0	0	0	0	0	0	(11,316)	36
37	**TOTAL Ownership**	(12,327)	(56,495)	1,954	0	0	0	0	0	0	0	0	(66,868)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(63,907)	(56,145)	(7,097)	0	0	0	0	0	0	0	0	(127,149)	45

Facility Name & ID Number PLEASANT VIEW # 0042416 Report Period Beginning: 1/1/05 Ending: 12/31/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				OSO PARTNERS	MARION, IOWA	BLDG. RENTAL
BIG MEADOWS, INC.	100%	BIG MEADOWS, INC.	SAVANNA			
AMERICAN HEALTH ENTERPRISES, INC	100%					
ALAN GAPINSKI	100%					
	0%	WINNING WHEELS, INC.	PROPHETSTOWN			
	0%	S.T.R.I.V.E.	PROPHETSTOWN			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	$ 155,697	OSO PARTNERS - BUILDING OWNERS	100.00%	$	$ (155,697)	1
2	V	30	DEPRECIATION				30,769	30,769	2
3	V	32	MORTGAGE INTEREST				68,433	68,433	3
4	V	19	PROFESSIONAL SERVICES				350	350	4
5	V	var	See Attached Page 6A	116,983	American Health Enterprises, Inc.	100.00%	109,886	(7,097)	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 272,680			$ 209,438	$ * (63,242)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number PLEASANT VIEW # 0042416 Report Period Beginning: 1/1/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		17	MANAGEMENT FEES	$ 116,983	AMERICAN HEALTH ENTERPRISES, INC.	100.00%	$	$ (116,983)	15
16	V		17	(SEE PAGE 8)		AMERICAN HEALTH ENTERPRISES, INC.	100.00%	90,593	90,593	16
17	V		19			AMERICAN HEALTH ENTERPRISES, INC.	100.00%	260	260	17
18	V		20			AMERICAN HEALTH ENTERPRISES, INC.	100.00%	206	206	18
19	V		21			AMERICAN HEALTH ENTERPRISES, INC.	100.00%	1,855	1,855	19
20	V		22			AMERICAN HEALTH ENTERPRISES, INC.	100.00%	13,629	13,629	20
21	V		24			AMERICAN HEALTH ENTERPRISES, INC.	100.00%			21
22	V		25			AMERICAN HEALTH ENTERPRISES, INC.	100.00%	717	717	22
23	V		26			AMERICAN HEALTH ENTERPRISES, INC.	100.00%	415	415	23
24	V		30			AMERICAN HEALTH ENTERPRISES, INC.	100.00%	924	924	24
25	V		32			AMERICAN HEALTH ENTERPRISES, INC.	100.00%	1,030	1,030	25
26	V		6			AMERICAN HEALTH ENTERPRISES, INC.	100.00%	257	257	26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 116,983			$ 109,886	$ * (7,097)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number PLEASANT VIEW # 0042416 Report Period Beginning: 1/1/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	AMERICAN HEALTH ENTERPRISES, INC.			100.00					$		1
2	ALAN GAPINSKI	PRESIDENT	DIRECT MANAGEMENT								2
3	(100% OWNER - AHE, INC.)										3
4											4
5	PLEASANT VIEW			100.00	26,280	10	20.00	MANAGEMENT	116,983		5
6	BIG MEADOWS, INC.			100.00	36,792	14	28.00	FEES	162,576		6
7	WINNING WHEELS, INC.			NONE	47,304	18	36.00	"	180,750		7
8	S.T.R.I.V.E.			NONE	13,140	5	10.00	"	111,250		8
9	OTHER (NON-COST REPORTING)			NONE	7,884	3	6.00	"	133,250		9
10											10
11											11
12											12
13								TOTAL	$ 704,809		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number PLEASANT VIEW # 0042416 Report Period Beginning: 1/1/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: AMERICAN HEALTH ENTERPRISES, INC.
Street Address: 501 6TH AVE. W.
City / State / Zip Code: LYNDON, IL 61261
Phone Number: (815-778-3683
Fax Number: (815-778-4503

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	DIRECT COST	1	1	$ 51,440	$ 51,440	1	$ 51,440	1
2	17	ADMINISTRATIVE	GROSS REVENUE	12,052,819	5	207,409	207,409	2,275,224	39,153	2
3	19	DATA PROCESSING	GROSS REVENUE	12,052,819	5	1,311		2,275,224	247	3
4	19	ACCOUNTING	GROSS REVENUE	12,052,819	5	68		2,275,224	13	4
5	20	DUES, FEES, SUBSCRIPTIONS	GROSS REVENUE	12,052,819	5	1,090		2,275,224	206	5
6	21	SUPPLIES, TELEPHONE	GROSS REVENUE	12,052,819	5	9,828		2,275,224	1,855	6
7	22	BENEFITS	% OF SALARY	454,180	5	68,329		90,593	13,629	7
8	24	TRAINING, SEMINARS	GROSS REVENUE	12,052,819	5	0		2,275,224	0	8
9	25	ADMIN. TRANSPORTATION	GROSS REVENUE	12,052,819	5	3,798		2,275,224	717	9
10	26	INSURANCE	GROSS REVENUE	12,052,819	5	2,199		2,275,224	415	10
11	30	DEPR'N.	GROSS REVENUE	12,052,819	5	4,895		2,275,224	924	11
12	32	INTEREST - VEHICLES	GROSS REVENUE	12,052,819	5	1,358		2,275,224	256	12
13	32	INTEREST - WORKING CAPIT	DIRECT COST	2	2	1,548		1	774	13
14	6	MAINT. SUPPLIES	GROSS REVENUE	12,052,819	5	1,362		2,275,224	257	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 354,635	$ 258,849		$ 109,886	25

Facility Name & ID Number PLEASANT VIEW # 0042416 Report Period Beginning: 1/1/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	MORTGAGE-SEE SCH.VIIB		X	MORTGAGE	$11,591.00	12/1/96	$ 1,350,000	$ 964,607	4/6/06	7.5000	$ 68,433	1
2	AMCORE BANK		X	CORPORATE VEHICLE	$1,003.00	9/06	32,000	28,803	9/09	6.5000	256	2
3												3
4												4
5												5
	Working Capital											
6	THE NATIONAL BANK		X	WORKING CAPITAL	$3,820.31	06/9/04			06/9/09	7.0000	24,741	6
7	OSO PARTNERS	X		WORKING CAPITAL	$1,636.21	12/8/96	167,700		12/8/10	6.7500	6,141	7
8	CORPORATE ALLOCATION	X		WORKING CAPITAL	NONE	6/2000	25,000	13,500	7/2010	5.0000	775	8
9	TOTAL Facility Related				$18,050.52		$ 1,574,700	$ 1,006,910			$ 100,346	9
	B. Non-Facility Related*											
10	INTEREST INCOME OFFSET		X								(1,012)	10
11	(SCHEDULE VI, PAGE 5)											11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,012)	14
15	TOTALS (line 9+line14)						$ 1,574,700	$ 1,006,910			$ 99,334	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** NONE **Line #**

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number PLEASANT VIEW **#** 0042416 **Report Period Beginning:** 1/1/05 **Ending:** 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	36,009	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	37,062	2
3. Under or (over) accrual (line 2 minus line 1).	$	1,053	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	37,062	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	38,115	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000	26,195	8
	2001	27,896	9
	2002	34,020	10
	2003	35,000	11
	2004	37,062	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PLEASANT VIEW COUNTY WHITESIDE

FACILITY IDPH LICENSE NUMBER 0042416

CONTACT PERSON REGARDING THIS REPORT ALAN GAPINSKI

TELEPHONE 815-778-3683 FAX #: 815-778-4503

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not b entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-17-130-001	PT NW SEC 17 TWP 21 RNG 5	$ 37,062.00	$ 37,062.00
2.		MF 10831-96 28603x	$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 37,062.00	$ 37,062.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2005

Facility Name & ID Number PLEASANT VIEW # 0042416 Report Period Beginning: 1/1/05 Ending: 12/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 23,743 B. General Construction Type: Exterior BRICK Frame METAL Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY GROUNDS		1996	$ 50,000	1
2					2
3	TOTALS			$ 50,000	3

Facility Name & ID Number PLEASANT VIEW # 0042416 Report Period Beginning: 1/1/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	74		1996	1974	$ 1,200,000	$	39	$ 30,769	$ 30,769	$ 276,823	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	WATER HEATER			1997	1,582	79	20	79		712	9
10	GARAGE/STORAGE			1997	1,670	84	20	84		752	10
11	BUILT-IN WHIRLPOOL BATHING SYSTEM			1997	22,217	2,222	10	2,222		19,291	11
12	CIRCULATING PUMP			1997	1,353		10			1,353	12
13	FLOOR TILE			1997	1,430	95	151	95		834	13
14	REMODEL OFFICES			1997	8,092	809	10	809		6,878	14
15	FURNACES			1997	16,130	1,075	15	1,075		9,319	15
16	ROOM SIGNAGE			1997	1,666	167	10	167		1,417	16
17	PAINTING			1997	12,962		7			12,962	17
18	LOCKS & PLATE PLAQUES			1997	820	82	10	82		697	18
19	WINDOW TREATMENTS			1997	772		5			772	19
20	WINDOW TREATMENTS			1997	5,228	523	10	523		4,444	20
21	DOOR ALARM SYSTEMS			1997	12,550	1,255	10	1,255		10,668	21
22	LANDSCAPING			1997	13,055	1,306	10	1,306		11,098	22
23	SEAL PARKING LOT			1997	2,926		5			2,926	23
24	OFFICE REMODELING (ADDT'L)			1998	6,367	76	7	76		6,367	24
25	BEAUTY SHOP REMODELING			1998	6,844	342	20	342		2,652	25
26	AIR CONDITIONING/HEATING UNITS			1998	6,332	422	15	422		3,025	26
27	SPRINKLER SYSTEM			1999	10,944	730	15	730		5,047	27
28	POLYVINYL FENCING			1999	2,133	142	15	142		936	28
29	GAZEBO			1999	7,383	492	15	492		3,199	29
30	REMODEL DINING ROOM			1999	20,459	1,023	20	1,023		6,223	30
31	INSTALL LIGHTS & CEILING FANS (NURSE STATION)			2000	989	49	20	49		292	31
32	65 GALLON WATER HEATER			2000	4,696	470	10	470		2,583	32
33	PLANTER INSTALLATION			2000	3,280	328	10	328		1,804	33
34	KITCHEN REMODELING			2001	13,860	924	15	924		4,620	34
35	AWNING			2001	2,504	250	10	250		1,126	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number PLEASANT VIEW # 0042416 Report Period Beginning: 1/1/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	CHANGE A/C COMPRESSOR	2001	$ 2,268	$ 227	10	$ 227	$	$ 1,021	37
38	REMODEL LAUNDRY ROOM	2001	4,714	121	39	121		514	38
39	HEAT TAPE GUTTERS	2001	1,603	160	10	160		721	39
40	CEILING, TILE, LIGHTS & INSTALLATION	2002	13,327	888	15	888		3,553	40
41	LAUNDRY ROOM FLOOR TILE	2002	1,125	75	15	75		300	41
42	COMMERCIAL DISPOSAL	2002	951	95	10	95		333	42
43	LAUNDRY ROOM A/C	2002	3,086	309	10	309		1,080	43
44	REPLACE ROOF	2002	47,430	2,372	20	2,372		7,708	44
45	SHUTTERS	2002	852	57	15	57		175	45
46	REMODEL HALLWAY	2003	26,281	2,628	10	2,628		6,570	46
47	MAIN STREET PROJECT	2004	25,169	3,596	7	3,596		5,393	47
48	PHYSICAL THERAPY WALKING AREA	2004	18,427	1,843	10	1,843		2,764	48
49	DECK	2004	8,535	853	10	853		1,280	49
50	GENERATOR	2004	59,537	2,381	25	2,381		3,969	50
51	SECURITY CAMERA	2004	1,519	217	7	217		325	51
52	ROOM WINDOWS	2005	1,448	42	20	42		42	52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,604,516	$ 28,809		$ 59,578	$ 30,769	$ 434,568	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number PLEASANT VIEW # 0042416 Report Period Beginning: 1/1/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 216,907	$ 29,361	$ 29,361	$	VARIOUS	$ 142,970	71
72	Current Year Purchases	7,732	510	510		VARIOUS	510	72
73	Fully Depreciated Assets	21,565					21,565	73
74								74
75	TOTALS	$ 246,204	$ 29,871	$ 29,871	$		$ 165,045	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	HOME OFFICE ALLOCATION			$	$	$ 924	$ 924		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$ 924	$ 924		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,900,720	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 58,680	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 90,373	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 31,693	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 599,613	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number PLEASANT VIEW # 0042416 Report Period Beginning: 1/1/05 Ending: 12/31/05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: OSO PARTNERS

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1974	74	1/1/03	$ 155,697	5	13	3
4	Additions							4
5								5
6								6
7	TOTAL		74		$ 155,697 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: [X] YES [ ] NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning 1/1/03
Ending 12/31/07

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/2006	$ 155,697
13.	12/31/2007	$ 155,697
14.	12/31/2008	$ 155,697

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ ____ Description: ____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	TRANSPORTATION	2005 FORD VAN	$ 500.00	$ 6,000	17
18					18
19					19
20					20
21	TOTAL		$ 500.00	$ 6,000	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number PLEASANT VIEW # 0042416 Report Period Beginning: 1/1/05 Ending: 12/31/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [X]
- COMMUNITY COLLEGE [ ]
- HOURS PER CNA 96

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [X]
- HOURS PER CNA 48

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)	622	3,072		3,694
4	Clinical Wages (b)		6,144		6,144
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments	1,130	4,520		5,650
8	CNA Competency Tests				
9	TOTALS	$ 1,752	$ 13,736	$	$ 15,488
10	SUM OF line 9, col. 1 and 2 (e)	$ 15,488			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$ none

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	8
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	3
2. From other facilities (f)	
TOTAL TRAINED	11

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number PLEASANT VIEW # 0042416 **Report Period Beginning:** 1/1/05 **Ending:** 12/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/05 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (106,487)	$ 193,190	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 269,662-22,331)	247,331	657,065	3
4	Supply Inventory (priced at COST)	34,305	79,608	4
5	Short-Term Investments			5
6	Prepaid Insurance	17,842	25,362	6
7	Other Prepaid Expenses	1,492	6,103	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):		43,000	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 194,484	$ 1,004,328	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	22,200	51,600	12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	404,516	430,984	15
16	Equipment, at Historical Cost	246,204	951,661	16
17	Accumulated Depreciation (book methods)	(322,790)	(945,027)	17
18	Deferred Charges	90	90	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): GOODWILL	67,158	67,158	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 417,378	$ 556,466	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 611,862	$ 1,560,794	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 99,950	$ 194,242	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		53,035	29
30	Accrued Salaries Payable	80,446	192,226	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,920	12,215	31
32	Accrued Real Estate Taxes(Sch.IX-B)	37,062	80,463	32
33	Accrued Interest Payable	1,983	29,949	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due To Big Meadows, Inc.	733,592		36
37	S.S. PAYABLE	394	484	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 957,347	$ 562,614	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	174,470	700,552	39
40	Mortgage Payable		197,389	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	RENTS PAYABLE - OSO PARTNERS	269,970	269,970	43
44	DUE TO AHE, INC.	25,288	251,195	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 469,728	$ 1,419,106	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,427,076	$ 1,981,720	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (815,214)	$ (420,926)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 611,862	$ 1,560,794	48

***(See instructions.)**

Facility Name & ID Number PLEASANT VIEW # 0042416 Report Period Beginning: 1/1/05 Ending: 12/31/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (551,106)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (551,106)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(264,107)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe) **Rounding**	(1)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (264,108)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (815,214)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number PLEASANT VIEW # 0042416 Report Period Beginning: 1/1/05 Ending: 12/31/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,254,736	1
2	Discounts and Allowances for all Levels	(9,600)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,245,136	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	6,342	6
7	Oxygen	14,595	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 20,937	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	19,387	11
12	Gift and Coffee Shop	113	12
13	Barber and Beauty Care	5,962	13
14	Non-Patient Meals	3,655	14
15	Telephone, Television and Radio	4,905	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 34,022	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,011	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,011	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	TRANSPORTATION-2834&LOSS ON LAND-(4082)	(1,248)	28
28a	EMPLOYEES @ OTHER FACILITIES	15,882	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 14,634	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,315,740	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	623,785	31
32	Health Care	1,091,486	32
33	General Administration	523,190	33
	B. Capital Expense		
34	Ownership	300,871	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	40,515	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,579,847	40
41	**Income before Income Taxes (line 30 minus line 40)****	(264,107)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (264,107)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number PLEASANT VIEW # 0042416 Report Period Beginning: 1/1/05 Ending: 12/31/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,059	2,112	$ 51,105	$ 24.20	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,635	5,953	121,852	20.47	3
4	Licensed Practical Nurses	13,035	13,905	240,558	17.30	4
5	CNAs & Orderlies	41,442	44,270	403,639	9.12	5
6	CNA Trainees	1,230	1,230	9,838	8.00	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,277	1,336	24,075	18.02	8
9	Activity Director	1,906	2,054	28,570	13.91	9
10	Activity Assistants	1,807	1,877	18,100	9.64	10
11	Social Service Workers	2,315	2,679	34,689	12.95	11
12	Dietician					12
13	Food Service Supervisor	1,883	2,115	25,544	12.08	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,516	19,549	147,789	7.56	15
16	Dishwashers					16
17	Maintenance Workers	4,463	4,825	60,212	12.48	17
18	Housekeepers	6,410	6,802	50,266	7.39	18
19	Laundry	4,043	4,290	31,703	7.39	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,904	2,096	25,468	12.15	23
24	Clerical	1,627	1,839	14,512	7.89	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,264	1,387	15,080	10.87	31
32	Other Health Care(specify)					32
33	Other(specify) TRANSPORTATI	908	1,010	10,803	10.70	33
34	TOTAL (lines 1 - 33)	111,724	119,329	$ 1,313,803 *	$ 11.01	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	165	$ 7,425	1,3	35
36	Medical Director	30	3,000	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	15	728	10,3	39
40	Physical Therapy Consultant	149	8,245	10a,3	40
41	Occupational Therapy Consultant	41	2,045	10a,3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	8	488	10a,3	43
44	Activity Consultant	23	920	11,3	44
45	Social Service Consultant				45
46	Other(specify) LAB	4	1,798	10,3	46
47	MOBILE X-RAY	4	548	10,3	47
48					48
49	TOTAL (lines 35 - 48)	439	$ 25,197		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number PLEASANT VIEW # 0042416 Report Period Beginning: 1/1/05 Ending: 12/31/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
DEANE PATTEN	ADMINISTRATOR	NONE	$ 51,440
(INCLUDED BELOW)			(51,440)
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
AHE, INC. MANAGEMENT CONTRACT	$ 116,983
(INCLUDES ADMINISTRATOR SALARY AND BENEFITS)	
TOTAL (agree to Schedule V, line 17, col. 3)	$ 116,983
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
CREATIVE SOLUTIONS	MEDICAL RECORDS	$ 4,093
ACHIEVE SOFTWARE	SOFTWARE MAINTENANCE	3,175
JOHN PYSE	COMPUTER CONSULTANT	2,024
SCHIFF-HARDIN LLP	LEGAL FEES	646
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 9,938

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 79,378
Unemployment Compensation Insurance	14,028
FICA Taxes	100,674
Employee Health Insurance	23,281
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
DISABILITY INSURANCE	13,381
LIFE INSURANCE	3,142
401K RETIREMENT	3,345
PHYSICALS	514
EMPLOYEE RECOGNITION	4,199
PROF. LICENSES & TUITION ASSIST.	2,974
HOME OFFICE ALLOCATION	13,629
TOTAL (agree to Schedule V, line 22, col.8)	$ 258,545

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 497
Advertising: Employee Recruitment	3,846
Health Care Worker Background Check	822
(Indicate # of checks performed 85)	
DUES & SUBSCRIPTIONS	6,920
ADVERTISING	21,940
PRINTING	2,241
COMMUNITY RELATIONS	3,011
MARKETING	1,395
HOME OFFICE ALLOCATION	206
Less: Public Relations Expense	(4,406)
Non-allowable advertising	(17,493)
Yellow page advertising	(4,448)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,531

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Travel and Seminar	6,570
(Detail Attached)	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,570

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number PLEASANT VIEW # 0042416 Report Period Beginning: 1/1/05 Ending: 12/31/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	PAINTING		$ 899	5	$ 180	$ 180	$ 180	$ 180	$ 89	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 899		$ 180	$ 180	$ 180	$ 180	$ 89	$	$	$	$

Facility Name & ID Number PLEASANT VIEW **#** 0042416 **Report Period Beginning:** 1/1/05 **Ending:** 12/31/05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ILLINOIS HEALTH CARE-$4236**

(3) Did the nursing home make political contributions or payments to a politica action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **7 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **16,127** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **40,515**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **NONE** Has any meal income been offset against related costs? **YES** Indicate the amount. $ **3,655**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **NONE**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.